Calendar No. 915

100TH CONGRESS
2d Session

SENATE

REPORT
100-493

DELAYING THE IMPLEMENTATION OF A CERTAIN RULE AFFECTING THE PROVISION OF HEALTH SERVICES BY THE INDIAN HEALTH SERVICE

AUGUST 25, 1988.—Ordered to be printed

Filed under the authority of the order of the Senate of August 11 (legislative day, August 10), 1988

Mr. INOUYE, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 2382]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2382) to delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is an amendment in the nature of a substitute.

PURPOSE

S. 2382 provides for a three-year delay in the implementation of a regulation proposed by the Department of Health and Human Services which would change the criteria for eligibility for medical care provided by the Indian Health Service. It would also direct the Office of Technology Assessment to conduct a study of the impacts of the proposed change and submit a report on this study to Congress.

BACKGROUND AND NEED

The Indian Health Service provides two types of services to Indian people which are governed by two different eligibility criteria: direct care at IHS facilities, and contract health care (care at non-IHS facilities provided pursuant to IHS referral and paid for by IHS).

S413-14

Direct care at IHS facilities is provided to individuals who can demonstrate Indian descendancy from either a federally-recognized tribe or a non-federally-recognized tribe. Residency on an Indian reservation is not required. Therefore, any Indian person can obtain services at any IHS direct-care facility in the country by presenting himself for care and documenting Indian descendancy.

Contract health care is provided to persons who can prove descendancy from a federally-recognized tribe, who live "on or near" an Indian reservation and who maintain "close social and economic ties" with that reservation. The eligibility criteria for contract health care is subject to administrative interpretation and the IHS interpretation of the criteria has been frequently criticized by Indian people who are rejected for contract health care because they do not "maintain close social and economic ties" with the Tribe or reservation in question.

The Indian Health Service began considering the issue of eligibility for services in 1983 when the Grace Commission recommended that IHS redefine its service population and serve only quarter-blood or enrolled members of federally-recognized tribes. Shortly after the Grace Commission report, an IHS Contract Health Services Task Force, convened by Dr. Everett Rhoades, Director of the Indian Health Service, to study the issue recommended that IHS serve only members of federally-recognized tribes who could meet a reservation residency requirement and who had formally applied and been determined to be eligible for IHS services. Also in 1982, the House Appropriations Committee directed IHS to define which Indians were eligible for services. These initiatives were in response to concerns about the increasing numbers of non-enrolled Indians (Indian descendants) receiving IHS services.

On June 6, 1983, the Department of HHS published a notice in the Federal Register requesting comments on various eligibility criteria. On June 10, 1986, a notice of proposed rule making to establish a more limited eligibility criteria for IHS services was published in the Federal Register. The final regulation was published on September 16, 1987 with a six-month delayed implementation date.

The proposed regulation would make three major changes in existing eligibility criteria:

(1) services would be limited to members of federally recognized tribes, with the exception of non-member minor children who would continue to receive services until the age of 19;

(2) contract health care coverage would be expanded to include all members of federally recognized tribes who reside in one of the IHS Health Service Delivery Areas; and

(3) a residency requirement for direct care at an IHS facility would be imposed.

Indian tribes have protested the implementation of the proposed regulation and contend that IHS did not adequately consult with the tribes about the change.

In response to widespread tribal concerns, Congress extended the implementation date of the proposed regulation by an additional six months in the FY 1988 Interior and Related Agencies Appropriations Act. In the absence of another extension, IHS will be authorized to begin implementation of the proposed eligibility criteria

on September 16, 1988. At present, IHS is proposing to provide services to everyone meeting either the old or new criteria until March 16, 1989, except that the residency requirement for direct care services will be imposed. After March 16, 1989, services will be denied to Indians who do not meet the new criteria. However, bill language has been included in the FY 1989 Interior and Related Agencies Appropriations bill which will prohibit IHS from implementing the regulations for an additional year.

Indian tribes and Alaska native villages have expressed strong opposition to the proposed regulation change because the impacts have not been determined. IHS has not conducted impact studies on the regulation and has been unable to advise Congress or the Indian tribes on how many Indians who currently receive care would become ineligible under the new regulation or on how many additional Indians would become eligible for contract health care. IHS has roughly estimated that approximately 125,000 Indians who currently receive care would lose eligibility under the new regulations.

States and county governments have also opposed the regulation because many of the Indians who would lose eligibility for IHS services are low-income and in all likelihood not have alternative resources to pay for health care. Rural hospitals located in proximity to Indian reservations are particularly concerned because they are faced with skyrocketing health care delivery costs and would be hard pressed to absorb additional costs of providing unreimbursed care to indigent Indians.

LEGISLATIVE HISTORY

Senator Melcher introduced S. 2382 on May 12, 1988. Senators Daschle, DeConcini, Wirth, Sanford and Reid are cosponsors. The Select Committee on Indian Affairs held a hearing on the measure on June 20, 1988 and the bill was ordered reported on July 29, 1988.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In open business session on July 29, 1988, the Select Committee on Indian Affairs, by a unanimous vote of a quorum present, ordered the bill, with an amendment in the nature of a substitute, reported with the recommendation that the Senate adopt the bill as amended.

SECTION-BY-SECTION ANALYSIS

Section 1. This section prohibits the Indian Health Service from implementing the proposed new eligibility rule for three years following enactment of the Act or from taking any steps to prescribe other rules which would have a similar effect.

Section 2. This section requires the Indian Health Service to provide services pursuant to existing eligibility criteria during the three-year period provided for in section 1.

Section 3. This section requires the Office of Technology Assessment, acting in consultation with the Indian Health Service, to conduct a study to determine the impacts of the proposed regulation or any other regulation which would change eligibility for

services. The study would include an area-by-area analysis of the financial and social impacts of the proposed changes. This section also requires consultation with affected Indian tribes and Alaskan Native Villages which would be affected by the proposed eligibility change. The study, along with the tribal comments and recommendations, would be forwarded to Congress two years after enactment of the Act.

Section 4. This section authorizes appropriation of such sums as may be necessary to carry out the Act.

COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 2382 as provided by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 12, 1988.

Hon. DANIEL K. INOUYE,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget office has prepared the attached cost estimate for S. 2382, a bill to delay the implementation of a regulation affecting the provision of health services by the Indian Health Service, as ordered reported by the Senate Select Committee on Indian Affairs on July 29, 1988.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM,
Acting Director.

Attachment.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 2382.
2. Bill title: None.
3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on July 29, 1988.
4. Bill purpose: To delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1989	1990	1991	1992	1993
Office of Technology Assessment study:					
Estimated authorization level	1.0	—	—	—	—
Estimated outlays	0.5	0.5	—	—	—

The costs of this bill would fall in budget subfunction 801.

Basis of estimate: S. 2382 would delay the implementation of a regulation that would change the eligibility criteria for Indian Health Service (IHS) provided medical care. The regulation is pro-

posed by the Department of Health and Human Services (HHS). In addition, the bill would require the Office of Technology Assessment (OTA) to study the eligibility changes and the financial and social impacts of the regulation. Based on information provided by OTA, the estimated cost of the study would be $1 million in fiscal year 1989.

The CBO assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

6. Estimated cost to State and local government: None.
7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Lori Housman.
10. Estimate approved by: C.G. Nuckols for James L. Blum, Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2382 will have no regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

Although the Committee has not received any communications from the Executive Branch with respect to S. 2382, the Administration did submit the following testimony on the bill.

STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee: I am Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am pleased to be here today to discuss our efforts to revise the eligibility criteria covering most of the IHS program and the proposal contained in S. 2382 which would delay implementation of these new regulations. I would like to begin with a brief discussion of the background which led up to the publication of the new eligibility regulations on September 16, 1987 (attachment 1).

The basic authority for IHS to provide services to Indians is the Snyder Act of 1921. The Act authorizes the expenditure of funds "for relief of distress and conservation of health" of "Indians throughout the United States". The Synder Act does not define eligibility requirements or the details of any program. That has been left to Departmental regulations and later acts of Congress.

Congress has generally provided funds for services to federally recognized Indians on or near reservations. The Federal Government's underlying policy is to serve Indians, not as individuals, but as members of Federally recognized governmental entities. The regulations currently governing eligibility for services from IHS require an individual to be "of Indian descent belonging to the Indian Community served by the local facilities and program". The regulations have been construed liberally to include anyone who

can reasonably be regarded as an Indian regardless of degree of Indian ancestry or tribal affiliation. These regulations were published in 1956.

IHS interpreted the regulations to authorize it to provide service to any otherwise eligible Indian who presented himself or herself to an IHS facility. Contract care, however, presented a problem in that it was not clear who was on or near a reservation. The growing importance of contract care increased the seriousness of the problem. Each IHS Area had its own policy which led to a suit and a court order for IHS to establish a uniform definition of what constituted "on or near a reservation". The result was the 1978 publication of regulations governing eligibility for contract health services including a definition of "on or near". In addition to meeting the older criteria, an individual would now also have to meet a defined residency requirement, i.e., "on or near", as well as demonstrate a close economic and social tie with the local tribe in order to be eligible for contract health services.

This was the only change affecting Indian eligibility for basic IHS services in the 32 year existence of the current eligibility regulations. Aside from this change, however, and notwithstanding the fact that the original regulation had well served both IHS and the Indian community for many years, there was increased dissatisfaction expressed with the regulation. There was a growing concern that IHS resources were being directed beyond what was thought to be the intended scope of the program. When health services were provided on the reservation or in areas primarily inhabited by closely knit Indian populations it was readily apparent who belonged to the community to be served. With shifts in population away from the reservations increasing inter-marriage, greater urbanization of traditionally rural areas (with a resulting increase in the Indian/non-Indian mix of the population), and the expansion of services to new areas through contract health care, individuals belonging to the Indian community were no longer as readily identifiable as in former times.

These problems were made worse by the rapid increase in the cost of medical care, the continued improvement in both the quality and accessibility of IHS services, the increased acceptance by the Indian community of the IHS program and the growing Indian population all of which combined to dramatically increase the demands placed upon the IHS system. Simply put, the question became how many "real" Indians is IHS serving and do the current regulations still provide effective and understandable criteria, both for the Indian people and those who administer the program? A corollary to this question is, are the criteria consistent with Congressional intent as expressed in legislation? If not, then Congressional intent is what needs to be clarified.

Alternatives were suggested by the Grace Commission and the 1983 Director's Task Force on Contract Health Services. The Grace Commission criticized IHS regarding its methods of determining Indian eligibilty. The Commission recommended that IHS define its service population as members of Federally recognized Indian tribes with at least 1/4 degree of Indian blood.

The Director's Task Force on Contract Health Services recommended that IHS eligibility be limited to persons of Indian blood

who: are members of Federally recognized tribes; live within a clearly defined service area; and formally applied for IHS services.

Congress itself had recognized the problem when it directed that: "IHS must address the issue of an expanding service population in terms of defining who is or should be eligible for IHS services * * *". (H.R. Rep. No. 97-942, 97th Cong. 2nd Sess. at pg. 108, 1982).

As a result of the above, the Department initiated a process leading to the publication of new eligibility regulations on September 16, 1987.

Since there has been concern expressed in many quarters that this was done without consultation with the tribes and the Indian people, I would like to briefly outline the process that was followed before turning to a discussion of the new regulations themselves.

On June 6, 1983, two Federal Register notices (48 FR 25273) were published which solicited comments on a number of options for eligibility criteria and verification (attachment 2). Copies of these notices were sent to each tribe and interested Indian organization.

A total of 242 responses were received. These consisted of 28 from tribal governments, 4 from tribal organizations, 15 from other Indian organizations, 4 from other organizations, and 191 from individuals. Of the 191 comments from individuals, 186 were form letters from Minnesota stating that IHS should retain its current eligibility requirements. In general, the 51 tribes and other organizations responding supported use of a blood quantum requirement for IHS eligibility. They were concerned, however, that changes must be made carefully to avoid hurting a large number of Indians where unemployment is a problem and no health insurance exists. The majority of the tribes responding stated that if a blood quantum criteria must be imposed, ¼ Indian blood should be the criteria employed.

On June 10, 1986 the Department published a notice proposing changes in the IHS eligibility regulations (attachment 3). Again, a copy of the notice was sent to each Federally recognized tribe and interested Indian organization. The comment period was originally 120 days. This was extended to 150 days following requests from a number of Alaska Native organizations which were having difficulty meeting the schedule because of the fishing season (attachment 4).

During the comment period, IHS sponsored over 120 public meetings, some with translators and all locally scheduled and advertised, resulting in over 10,000 pages of transcripts. Copies of these transcripts were provided to this Committee. In addition, we received over 11,000 submissions from 16,000 commentors ranging from individuals to 172 tribes. All issues and suggestions raised were considered. The final rule represents a careful consideration and balancing of all views.

Though it may be true that many tribes and Indian people do not agree with the final regulations, it is not true that they were not consulted and their views seriously considered. The new regulation was the result of a process that took over four years.

We are all aware that there is a great deal of opposition being expressed by the Indian community against implementation of the new regulation. This was made very clear to me by the Indian at-

tendees at a recent tribal consultation meeting sponsored by the IHS at Nashville. As promised, I have forwarded their concerns and views to the Assistant Secretary of Health. But many of the fears expressed were based on misunderstanding of the regulation such as the belief that IHS was requiring tribes to have an enrollment system. We are currently developing training materials for IHS and tribal personnel who will implement and administer the regulations. We plan to utilize these materials to orient our service population in order to correct these misunderstandings.

I would like to turn now to the regulation itself and briefly describe what it provides. In some case I will go into more detail to try to correct some misunderstandings which I believe are widely held.

The major issue raised during the comment period concerned the proposal to have a ¼ blood quantum test which was opposed by the overwhelming number of those who commented. Of the more than 16,000 commentors who opposed the blood quantum criteria, including Members and Committees of Congress, a majority did so at least partially on the basis that tribal membership should be a sufficient criteria. Interestingly enough, at least 125 tribes have blood quantum of at least ¼ degree as a membership requirement.

In response to the comments, the blood quantum requirement was dropped from the final regulation and the requirement for tribal membership retained. The only exception to tribal membership is for minor children who are not themselves eligible for membership but who are natural children of tribal members. Eligibility for tribal membership is not sufficient. There is to be a uniform residency requirement for both direct and contract health. The resulting health service delivery areas (HSDA) can be adjusted administratively rather than requiring legislation or a change in regulations as is currently the case with contract health service delivery areas (CHSDA). Former residents of HSDAs may go to any HSDA for direct (not contract) services. Appeal procedures are provided for denials of either direct or contract services. The close economic and social ties test is abolished. Beneficiary Identification Cards are to be issued. The rule is uniform nationwide.

I would like to address the major issues as I understand them. With regard to tribal membership, three major issues have surfaced. Two deal with evidence needed to document tribal membership. First, a number of tribes have expressed concern that they do not have enrollment systems. The Bureau of Indian Affairs (BIA) has expressed similar concern. The regulations do not require an enrollment system. Though an enrollment system would be acceptable, the regulation is very broad stating that membership can be demonstrated "as prescribed by the charter, articles of incorporation, or other legal instruments or traditional processes of the tribe" (42 CFR 36.16(b)(1)).

Any method by which a tribe identifies its members is acceptable. This approach is consistent with self-determination, tribal sovereignty, and the government to government relationship since the tribes will determine and verify who their members are.

Second, concern has been expressed with the method of determining tribal membership, i.e. certification by the BIA (42 CFR 36.16(b)(2)). The intent here was not to put the BIA into the posi-

tion of determining tribal membership. Indeed, this would have gone against the entire concept of this regulation in emphasizing tribal control. The purpose was to permit the BIA to act where it was authorized or required to so act by legislation, court order, tribal agreement etc. I have had a recent meeting with Assistant Secretary for Indian Affairs Swimmer to clarify this issue and have agreed to pursue the issuance of an interpretive rule or notice with the Office of General Counsel.

BIA is generally involved, however, in issuing Certificates of Degree of Indian Blood (CDIB). Though these do not always prove tribal membership they do establish Indian descent which is essential for tribal membership.

Third, we have become aware that a number of tribes are considering expanding their membership requirements. In some cases this membership will be solely for health service purposes and will be accomplished by establishing different categories of membership. Though this is apparently within the applicable laws, we are concerned with the long term consequences of such actions. In addition to eventually unfairly distorting the allocation of IHS resources, we are concerned with the long term effect on such tribes.

The concern has been expressed both that the purpose of the rule was to reduce the number of eligible Indians and that the rule will increase the demand for services. Those concerns are both partly correct. While it is true that the rule tightens eligibility requirements based on tribal membership and combines rules for direct and contract services, it was not intended simply to reduce the number of eligible Indians. Its purpose is also to enable IHS to better allocate resources, enhance coordination of patient care in IHS and non-IHS facilities, and administer the program.

On the other hand, under the new rules it is expected that the number of people eligible for contract health services (CHS) will increase. This is because the new rule does away with the "close economic and social ties" test previously required for off-reservation Indians. The IHS has estimated that approximately 125,000 Indians will become eligible for CHS under the new rules, excluding the impact of the tribal membership requirement. These are people who are already counted as part of the IHS service population. They simply will now be eligible for a service form which they were previously excluded because they did not have the needed close economic and social ties with the tribe within whose CHSDA they live.

However, only experience will show how many Indians will actually take advantage of their new CHS eligibility. This points out a problem with any study of the impact of a proposed eligibility criteria. Only experience will show how many of those theoretically eligible will take advantage of their eligibility. For example, though the current IHS eligible service population in California is estimated to be approximately 79,000, the IHS registration system shows a population of approximately 49,000 and a user population of about 40,000.

But the forgoing discussion of numbers obscures the real issue. The IHS is charged with the mission of raising the health status of Indians to the highest possible level. Without definitive program eligibility criteria there is ultimately no way to either effectively

direct resources to the target population, to accurately identify their needs and health status, or to measure the IHS impact on their health status. The goal of the Indian Health Care Improvement Act will be made immeasurably more difficult without conforming eligibility requirements.

The growing demand for IHS services, as evidenced by an expanding service population, will out-strip the supply of medical services that can be provided by any amount of IHS resources that can rationally be contemplated. This has greatly exacerbated the pressure on IHS to find ways to ration contract health services to the Indian population in ways that meet the often conflicting demands for more health care, equity in the distribution of resources, and the mission to raise the health status of Indians to the highest possible level. As a result we are frequently in the unsatisfactory and ultimately untenable position of providing contract health services only in emergency and life threatening cases.

The above does not mean that we have not made estimates of the overall impact of the new regulation. The IHS does not have extensive data on tribal membership. The IHS patient registration system will be updated with tribal membership information as part of the implementation process for the new eligibility regulations. However, by using current IHS patient registration data, BIA tribal enrollment data and data from the 1980 Census Supplementary Questionnaire for American Indians, we have estimated that 100,000 to 150,000 people who now utilize IHS services are not members of a federally recognized tribe. We anticipate that many of the people who are not currently members of a federally recognized tribe will become members in order to retain their eligibility. The impact will vary by IHS Area, but this can only be determined once experience is gained with the new rules in terms of the net change in actual users and utilization. It should be noted that similar difficulties would exist for any proposed eligibility criteria.

It is true that we do not have enough data to make reasonable impact estimates on an Area by Area or Service Unit by Service Unit basis. An earlier attempt to obtain base data on membership, blood quantum, and residency was halted when the cost of obtaining such information rose above what was available. An early test of the study was met with some resistance to providing data from a number of tribes. IHS does not have easy access to all the sources of data that would be required to make site by site estimates.

Costs of such an effort would depend upon the detail and reliability desired. For example, we have estimated that the detailed study of California Indians required by the proposed amendments to the Indian Health Care Improvement Act, Public Law 94-437, would cost over $600,000. We do not believe such detail is warranted in this case, therefore the cost from the California estimate should not be extrapolated to the entire nation. Nevertheless, we are talking about a considerable effort that would be costly. I would suggest that, if a study is considered necessary, a statistical approach would be more appropriate and timely and that it should be done by the Congressional Office of Technology Assessment or some similar body experienced in such impact assessments.

Another major concern is how to deal with those who will lose eligibility. We do not plan to "* * * Jerk the rug out from under

them." A great deal of thought has gone into providing a sensitive and humane transition. Much of the approach reflected in the regulation was first developed by IHS in the transition that followed enactment of the statute that restricted the eligibility of non-Indian spouses to a few specified situations.

Originally, the regulation was scheduled to take effect six months after publication, followed by a six-month grace period during which those who would lose eligibility under the new rule and who had utilized IHS or IHS funded facilities within three years prior to the publication date would continue their eligibility. Language in the Fiscal Year 1988 Appropriations Act, Public Law 100-102, further delayed implementation until September 16, 1988.

The regulations provide a number of transition provisions which would mitigate its impact on anyone no longer eligible under the new rules. These provisions include the grace period, provision for minor Indian children, and provisions to assure continuity of care for persons under active treatment or with chronic degenerative conditions on the day they lose eligibility for up to an additional year beyond the grace period. Further, the regulation provides appeal rights to those losing eligibility and requires that those patients be offered assistance in locating other health care providers and medical assistance programs.

Thus, those with the means to obtain insurance would have ample time to do so. Those without means would have ample time and IHS assistance in applying for other medical assistance programs. Emergency services would continue to be available on the same basis as it is to non-beneficiaries today. Those under treatment would not be abandoned. Special provisions would apply to minor Indian children and those with chronic degenerative conditions. An appeals process would be available to all.

In the same spirit of concern for those who are not getting needed services, however, I would be remiss if I did not also point out that anecdotal information indicates that there are many tribal members, often reservation residents with a high degree of Indian blood, who are being squeezed out of services in IHS facilities by people with very tenuous, if any, tie to an Indian tribe or their Indian ancestry.

I would like to return to the issue of tribal membership as an eligibility requirement. We believe tribal self-determination calls for such an approach. In addition, Congress has in recent years defined "Indian" in several related statutes essentially to mean a person who is a member of a federally recognized tribe. The Indian Self-Determination and Education Assistance Act (Public Law 93-638), a dominant statute guiding the federal government's present relationship with Indian tribes, defines an Indian as "a member of an Indian tribe" (25 USC 450b(a)). The Indian Health care Improvment Act has a definition similar to Public Law 93-638 relative to federally recognized Indians (25 USC 1603(c)) and both have the same definition of an "Indian Tribe."

The Omnibus Drug Bill, Public Law 99-570 ("Subtitle C—Indians and Alaska Native") contains a provision restricting the target population for the Indian Health Service portion of the Act to "* * * members of Indian tribes" (section 4226(4)). The term "Indian

tribe" is defined exactly as that term is defined in Public Law 93-638 to mean federally recognized tribes (section 4204(3)).

Moreover, statutes restoring or recognizing the Federal trust relationship and Federal Services to Indian tribes consistently provide for restoration of federal services and benefits to ". . . members of the tribe * * * ." The most recent example of this is the August 18, 1987, Ysleta Del Sur Pueblo and Alabama and Conshatta Indian Tribes of Texas Restoration Act, Public Law 100-89. In those few instances where Congress has wanted broader eligibility it has very specifically spelled out its intent, e.g., the urban Indian, manpower, and alcoholism programs in Public Law 94-437.

In light of this evidence of Congressional intent, we are somewhat surprised by Congressional and Indian expressions in favor of a further delay in the implementation of a rule which fully meets the expressed requirements of the Congress and which acknowledges that it is the tribes themselves that should determine who their members are and, therefore, who is eligible for IHS services.

It should also be pointed out that proposals in both Houses of Congress to amend the Indian Health Improvement Act contain directives to identify unmet health needs of Indians and to direct resources to these needs. "Indians" is defined in both the House and the Senate bills as members of federally recognized tribe except for those special programs mentioned above. It would make a nullity of much current and proposed legislation to have inconsistent eligibility criteria, to say nothing of the impossibility of meeting those previously mentioned tests of equity, access, and improvement of Indian health status.

The Constitutional and statutory basis for the IHS program is not race but the government-to-government relationship between the Federal government and the Indian tribes.

We understand that history has sometimes resulted in what can most charitably be described as a confused tribal status. But these situations are political not medical problems and are beyond the ability of the IHS to correct.

In addressing the specific situation in California, the preamble to the final regulation contains a statement that is applicable elsewhere.

> We believe the most reasonable and prudent poilcy (sic) with respect to eligibility for services from the IHS is to make it clear that such services are available to members of Federally recognized tribes. It is within the jurisdiction of the BIA Federal acknowledgement program and the Congress to correct any historical anomalies with respect to Indian groups not now recognized.

The same analysis applies to determining individual Indian status.

This Committee is actively engaged in addressing these very difficult problems. Today's hearing is only one of a series and I commend the Committee for its efforts.

I am sympathetic to the Committee's concern with the lack of definitive data on the impact of the eligibility rule. I experienced the same concern and frustration. But eventually I had to take the position that the IHS must follow the lead of Congress and define

who "should be eligible" for services and mitigate any adverse impact of that decision with what I hope are fair and humane transition procedures. For me to have approached it otherwise would, I fear, have resulted in nothing being done.

S. 2382, a bill to delay the implementation of a certain rule affecting the provision of health services by the Indian Health Service, calls for a three year moratorium on implementation, and a two year detailed study of the local impact of the regulation with consultation with tribal governments and urban Indian health care programs.

Consultation with urban Indian organizations is not appropriate in this case. Urban programs are funded by IHS under Title V of Public Law 94-437. Eligibility for these programs is covered by a separate statutory definition of Indian which is not affected by the new regulation. The urban Indian program eligibility definition is considerably broader than that contained in the regulation. Consultation with the tribes and the individual Indians affected (including those living in urban areas) is, however, appropriate.

The need for modification of eligibility requirements is as urgent now as when the process was initiated. Setting limits on the eligible service population will enable us to focus the available IHS resources so that services can be better directed at health needs in a manner that will maximize the effect of our resources on the Indian community. To retain the current eligibility rules would leave unaddressed the growing perception that IHS resources are being directed beyond the intended scope of the program and will not provide IHS with the tools necessary to better plan and focus its resources. The new regulations simplify, clarify, and tighten eligibility requirements without being overly restrictive and without creating major disruptions in service delivery patterns.

To a limited extent Congress is considering the question of who should be eligible for no charge services from the IHS in the pending bills to amend the Indian Health Care Improvement Act (i.e S. 129 and H.R. 2290). We believe this is a more appropriate mechanism than a moratorium and study as proposed in S. 2382.

That ends my prepared statement. I will be happy to attempt to answer any questions you may have.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 2382 will not result in any changes in existing law.

○